STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING Director's Office	C 01/09/2009

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from January 5, 2009 through January 9, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was one-hundred fifteen (115). The survey sample totaled twenty-three (23) residents which included a review of twenty (20) active and three (3) closed residents' clinical records.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	F279 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS 1. Resident #5 remains in the center. The resident has been reviewed by the ICP team and changes have been made to the plan of care as necessary. Current residents are reviewed with each significant incident to determine that the plan of care is updated to reflect their current level of care. 2. In-servicing shall be held on or before March 16, 2009, for licensed nursing staff on Comprehensive care planning. 3. Monthly and periodic audits shall be completed to determine compliance with care planning. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	3/16/09 3/16/09 ongoing ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alex "Lou" NHA — TITLE: Administrator — (X6) DATE: 3/11/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 by: Based on record review and interviews it was determined that the facility failed to review and revise a comprehensive care plan for one (#5) out of 23 residents in the sample. Findings include: Cross refer F323. Review of Resident #5's care plan following the incident on 3/29/08 in which the resident admitted drinking a liquid deodorizer, the care plan failed to address a focus, goal or interventions to prevent a future occurrence of ingestion of non-consumable liquids. The facility failed to identify an accidental hazard to ensure the safety of Resident #5.	F 279		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to provide nailcare for two (2) resident's (#5, #14) out of twenty-three (23) sampled residents. Findings include: 1. Resident #5 was admitted to the facility on 03/06/06 and had a history of elongated hypertrophic toenails with subungual debris, crumbling nail plates and fungal malodor. A review of the latest physician orders, dated	F 312	F312 483.25(a)(3) ACTIVITIES OF DAILY LIVING 1. Resident's #5 and 14 remain in the center and have been seen by the podiatrist for nail care. Current resident's have been assessed for nail care and if necessary were seen by the podiatrist. 2. In-servicing shall be held on or before March16, 2008, for nursing staff on nail care. 3. Monthly and periodic rounds shall be completed to determine compliance with nail care. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	3/16/09 3/16/09 ongoing ongoing

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F 312	Continued From page 2 November 2008, reflected a standing order for podiatry consults for evaluation and treatment for long and painful nails. Nurse #1 confirmed that the last podiatry consult was performed on 07/24/08 as indicated by record review. On 01/07/09 at 9:20 AM, Resident #5's nails were observed with Nurse #2 who confirmed the nails were long and in need of care. 2. Resident #14 was admitted to the facility on 04/07/00 and had a history of elongated hypertrophic toenails with subungual debris, crumbling nail plates and fungal malodor. A review of the latest physician orders, dated November 2008, reflected a standing order for podiatry consults for evaluation and treatment for long and painful nails. Nurse #1 confirmed that the last podiatry consult was performed on 05/24/07 as indicated by record review. On 01/07/09 at 2:45 PM, Resident #14's nails were observed with CNA #1 who confirmed the nails were long and in need of care. The facility failed to provide podiatry care on a routine schedule as recommended by the attending physician and as indicated by the needs of Resident's #5 and #14.	F 312		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 483.25(d) URINARY INCONTINENCE 1. Resident #23 no longer resides at the center. All current residents on antibiotics were reviewed to determine proper transcription and administration. Current residents with urine cultures ordered or that have had cultures in the hospital prior to admit are monitored to determine the results are received in a timely manner for appropriate treatment. Current resident's goals for care have been reviewed and resident's wishes have been included in the plan of care. Continued →	3/16/09

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F 315	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (1) resident (#23) out of twenty-three (23) sampled residents received the appropriate treatment for an urinary tract infection (UTI). The facility failed to administer an order for Cipro (an antibiotic) as ordered and failed to obtain the final urine culture and sensitivity results. Additionally the facility failed to include one of the physician goals in the resident's care plan. Findings include: Resident #23 was re-admitted to the facility on 8/27/08 from the hospital following a repair of a right hip fracture. The resident had diagnoses including cardiomegaly, chronic obstructive pulmonary disease, hypertension, and history of leukocytosis (elevated white blood cells). Re-admission Minimum Data Set (MDS) assessment dated 9/3/08 indicated the resident had an UTI within the past 30 days. Review of the hospital's discharge summary dated 8/27/08 indicated that the preliminary urine culture after one day showed no growth. Record lacked evidence that the final urine culture and sensitivity (C & S) was obtained by the facility from the hospital. A review of the re-admission physician order sheet dated 8/27/08 revealed an order for Cipro (an antibiotic) 250 mg. (milligram) one tablet by mouth every 12 hours for ten days. A review of the Medication Administration Record	F 315	F315 Continued → 2. In-servicing shall be held on or before March 16, 2009 for licensed nursing staff on Lab study results, transcription of physician orders, and care planning. 3. Audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	3/16/09 ongoing ongoing

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F 315	Continued From page 4 (MAR) from 8/28/08 through 8/31/08 (four days) revealed an error in transcribing the order for the Cipro every 12 hours. The row for the 8 PM dose had "1, 2, 3, 4" indicating the number of the day of the Cipro administration, thus, the MAR lacked evidence that the 8 PM dose was administered for the above four doses/days. Review of the attending physician admission history and physical examination dated 8/30/08 documented that Resident #23 was not eating and drinking well and had an increase heart rate with diaphoresis. In addition, the resident's son was contacted by the attending physician and the other son was contacted to discuss Resident #23's health status. (It appears that contact with one of the sons was never completed) The plan/goals on the document was comfort and long term care. However the physician failed to include this goal of comfort care on the physician orders. Consequently the facility failed to develop a care plan of comfort care. Review of CBC (complete blood count blood test) dated 8/28/08 revealed elevated WBC (an indication of possible infection) of 17.4 in which the attending physician was made aware of the results. No new physician orders were received. The subsequent CBC dated 9/2/08 revealed further elevation in WBC of 34.8. Although the facility informed the physician of the above result, the facility failed to thoroughly reassess the resident who was being treated with an antibiotic and failed to obtain the results of the hospital culture and sensitivity. An interview with an administrative nurse on 1/7/09 at 1 PM revealed that in order to obtain	F 315	PAGE LEFT BLANK INTENTIONALLY	

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F 315	Continued From page 5 laboratory results from the hospital, the facility's system required that the facility initiate obtaining the final results from the hospital. For Resident #23, the facility failed to request the final urine culture and sensitivity (C & S) result. Subsequent to the surveyor's inquiry, the facility obtained the copy of the final urine C & S report dated 8/30/08 timed 6:30 PM on 1/7/09 which indicated a positive urine culture with Escherichia Coli (bacteria) which was resistant to Cipro. Due to the facility's failure to request the final urine C & S results, the physician was not made aware of the infection being resistant to Cipro. The above findings were reviewed with administration on 01/20/09.	F 315		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and observation the facility failed to ensure that one (1) resident (#5) out of twenty-three (23) sampled resident's environment was free of accident hazards. Findings include: Resident #5 was admitted to the facility on 03/06/06 with a diagnosis of dementia and had a diverting colostomy (an attached appliance for	F 323	F323 483.25(H) ACCIDENTS AND SUPERVISION 1. Resident #5 remains in the center. All potential hazardous liquids were removed from the resident's room. Rounds have been completed throughout the facility to determine that all resident areas are free from accident hazards. 2. In-servicing shall be completed for facility staff on accident hazards on or before March 16, 2009. 3. Monthly and periodic rounds shall be completed to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	3/16/09 3/16/09 ongoing ongoing

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F 323	Continued From page 6 stool evacuation). On 03/29/08, Resident #5 called a nurse to her room stating she was vomiting. A cup with a blue residue was noted on the nightstand with lipstick on the rim of the cup. Liquid colostomy deodorizer (blue in color) was also noted on the nightstand. Resident #5 admitted to drinking "just a taste of" the deodorizer. She was sent to the Emergency Department for evaluation of nausea and vomiting. Discharge instructions stated to "keep supplies out of reach of patient." On 01/07/09 at 8:20 AM and 01/08/09 at 1:45 observations were made of Resident #5's room reflecting nailpolish remover, mouthwash and liquid room misting deodorizer in the bathroom.	F 323		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 483.25(l) UNNECESSARY DRUGS 1. Resident's #1, 8, and 15 remain in the center. Resident's # 1 and #8 have appropriate documentation for PRN administration of their anti-anxiety medications. Residents #1 and 8 have been reviewed by the ICP team and their plans of care have been updated to reflect their current level of care. Resident #15 has been assessed for side effects of "Abilify." Resident #13 no longer resides in the center. Current residents have been reviewed for documentation related to the need for PRN medications and monitoring of side effects of antipsychotic medications. 2. In-servicing shall be completed on or before March 16, 2009 for licensed nurses on documentation related to administration of PRN medications and AIMS testing for antipsychotic medications. Continued →	3/16/09 3/16/09

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F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure four (4) residents (#1, #8. #13, #15) out of twenty-three (23) sampled residents received adequate monitoring for the use of psychoactive medications. Findings include: 1. Resident #1 had a physician's order for Xanax (antianxiety medication) 0.25 mg. every eight hours as needed. In November 2008, four doses were administered to the resident. One out of four doses had staff documentation of the reason for use and the effectiveness. In December 2008, four doses were administered to the resident. One out of four doses had staff documentation of the reason for use and the effectiveness. The resident had a diagnosis of anxiety disorder but did not have a care plan to address non pharmalogical measures used to reduce or prevent anxiety. An interview with nursing staff on 1/7/09 confirmed these findings. 2. Resident #8 had a physician's order for Ativan (antianxiety medication) 1 mg. every 4 hours as needed for anxiety. In October 2008, Ativan was administered 12 times. Only five times did staff document the reason or effectiveness for the use of this medication.	F 329	F329 Continued → 3. Monthly and periodic audits shall be completed over to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	ongoing ongoing

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F 329	Continued From page 8 In November 2008, Ativan was administered 21 times. Only six times did staff document the reason or effectiveness for the use of this medication. In December 2008, Ativan was administered 30 times. Only 12 times did staff document the reason or effectiveness for the use of this medication. The resident's care plan did not contain any specific approaches related to anxiety and non pharmalogical interventions. 3. Resident #13 had a physician's order for Ativan 1 mg. three times a day as needed for anxiety. During December 2008, Ativan was administered 28 times. Each of these doses was administered in the evening between 7:30 and 9:00 PM. Only twice was there documentation as to why the drug was administered with nursing notes stating for anxiety. The effectiveness was not documented. A staff interview on 1/5/09 revealed that the resident took the Ativan almost every night to help her sleep. The resident had diagnoses of anxiety and insomnia. The resident had no care plan to address anxiety or insomnia including non pharmalogical interventions. 4. Resident #15 was admitted to the facility on 06/28/02 with the mental health diagnosis of Bipolar Disorder. On 05/09/07 a physicians's order for Abilify U-D (antipsychotic medication) 20 mg. was written. A record review revealed since the administration of the drug and to date, there was no monitoring of this drug to ascertain or detect any complications or adverse	F 329	PAGE LEFT BLANK INTENTIONALLY	

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F 329	Continued From page 9 consequences of the treatment although the monthly pharmacy review was conducted. On 01/10/09 at 10:45 AM, the Director of Nursing stated the drug was not on the facility's list of antipsychotic medications currently being monitored. However, the policy was updated during the survey to include the drug Abilify for monitoring.	F 329		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure ten (10) residents (#2, #3, #5, #6, #7, #8 #10, #12, #15, #19) out of twenty-four (24) sampled residents were seen by a physician at the required schedule. Findings include: 1. Resident #2 had physician visit notes dated 3/11/08, 6/19/08 and 9/26/08. The physician did not visit every 60 days. 2. Resident #3 had a physician visit 3/20/08 and then not again until 7/9/08. 3. Resident #5's last physician progress note was dated 10/20/08. The physician did not visit every	F 387	F387 483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS 1. The records of resident's (#2, #3, #5, #6, #7, #8, #10, #15 and #19) have been reviewed and corrective action (with exception of in-ability to make up for missed visits) and will be completed no later than March 16, 2009. 2. Discussions and training regarding this standard of care have taken place with the appropriate physician's and the Medical Director. Weekly audits with "to do" lists are in place and being monitored. 3. Weekly and periodic audits are being done to monitor compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	3/16/09 3/16/09 ongoing ongoing

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F 387	Continued From page 10 60 days. 4. Resident #6's last physician progress note was dated 03/13/08. The physician did not visit every 60 days. 5. Resident #7's last physician visit note was dated 3/13/08. 6. Resident #8 had a physician visit 5/22/08 and then not again until 8/22/08. 7. Resident #10's last physician progress note was dated 10/23/08. The physician did not visit every 60 days. 8. Resident #12's last visit was at the time of her admission history and physical on 10/16/08. Subsequent physician visits every 30 days did not occur. 9. Resident #15's had a gap in visits between 08/15/08 through 12/11/08. The physician did not visit within 60 days following 08/15/08. 10. Resident #19's only visit was at the time of her admission history and physical on 11/19/08. Subsequent physician visits every 30 days did not occur. An interview with facility administrative staff confirmed these findings. The physician who failed to maintain the resident visit schedule is also the medical director. This is a repeat deficiency from the annual survey ending 2/26/08.	F 387		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425	F425 483.60(a),(b) PHARMACY SERVICES 1. Resident #21 no longer resides in the center. Current and new resident's medication orders are being received from the pharmacy in a timely manor. This negative scenario has been virtually eliminated with the installation of an Omnicell system for 24-hr. on-site availability. Continued →	ongoing

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F 425	Continued From page 11 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, review of the clinical record, and other facility documents it was determined that the facility failed to ensure that pain medication was acquired for one (#21) resident out of twenty-three (23) sampled residents. Resident #21 was admitted from the hospital at 7:35 PM on 4/25/08 and the ordered medications were not delivered to the facility until 6:36 AM on 4/26/08 (greater than 11 hours). Findings include: Review of Resident #21 nurses' notes dated 04/25/08 timed 7:35 PM, 8:40 PM and 10 PM documented resident's complaints of extreme pain. Additionally, the resident asked for a pain medication, as documented in the nurse's note dated 04/26/08 timed 3:00 AM.	F 425	F425 Continued → 2. In-servicing shall be completed on or before March 16, 2009 on obtaining medications from the pharmacy. Training on use and access of Omnicell has already been completed. 3. Monthly and periodic audits shall be completed to determine compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	3/16/09 ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 01/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 425	Continued From page 12 The resident was ordered Demerol (narcotic pain medication) 100 mg. (milligrams) one tablet by mouth every four hours as needed for severe breakthrough pain. The facility's interim box did not include Demerol. A record review revealed the facility followed the established protocol for acquiring the medications and was anticipating the delivery of the medications, including Demerol by 3 AM on the morning of 04/26/08, thus, did not initiate utilizing the back-up pharmacy. Record review revealed the medications did not arrive at the facility until 6:36 AM on 4/26/08. An interview with pharmacy representative on 01/07/09 at 10 AM revealed that the facility followed the established process however, the contracted pharmacy failed to delivery the medication timely. Findings reviewed with administration on 01/07/09.	F 425		
F 514 SS=B	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 483.75(l)(1) CLINICAL RECORDS 1. The records of resident's (#2, #3, #5, #6, #7, #8, #10, #15 and #19) have been reviewed and corrective action (where possible) will be completed no later than March 16, 2009. 2. Discussions and training regarding this standard of care have been completed with the appropriate physician's and the Medical Director. 3. Monthly and periodic audits shall be completed to determine compliance; this shall be the responsibility of the DON/designee. Continued →	3/16/09 ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to ensure complete medical records for eight (8) residents (#1, #3, #5, #6, #10, #15, #18, #20) out of twenty-three (23) sampled residents. The physician was not signing the monthly physician order sheets and telephone orders in a timely manner. Findings include: 1. Resident #1 had verbal/telephone physician orders dated 11/3, 11/7, 11/16, 11/18, 11/26 and 11/28/08 that had not been signed by the physician as of 01/07/09. 2. On 01/07/09 Resident #3's physician order sheet for December 2008 remained unsigned by the physician. 3. On 01/07/09, Resident #5's physician order sheet for December 2008 remained unsigned by the physician. 4. On 01/07/09, Resident #6 had unsigned telephone verbal orders by the physician dating back to 09/11/08. 5. On 01/07/09, Resident #10's physician order sheet for December 2008 remained unsigned by the physician. 6. On 01/07/09, Resident #15's physician order sheet for December 2008 remained unsigned by the physician. 7. On 01/07/09 Resident #18's physician order sheet for December 2008 remained unsigned by the physician.	F 514	F514 Continued → 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	ongoing

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F 514	Continued From page 14 8. On 01/07/09, Resident #20's physician order sheet for December 2008 remained unsigned by the physician. An interview with administrative staff confirmed these findings.	F 514	PAGE LEFT BLANK INTENTIONALLY	

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Wilmington, Delaware 19806
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STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center

DATE SURVEY COMPLETED: 1-9-09

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal report. **An unannounced annual survey and complaint visit was conducted at this facility from January 5, 2009 through January 9, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was one-hundred fifteen (115). The survey sample totaled twenty-three (23) residents which included a review of twenty (20) active and three (3) closed residents' clinical records.** **3201 Nursing Home Regulations for Skilled Care**	
3201.9.1.1	**General Services:** **The skilled care nursing facility shall provide to all patients the care deemed necessary for their comfort, safety, nutritional requirements and general well-being.**	General Services: Refer to CMS2567-L survey completed 1/9/09, F312, F315, F323, F329, F425 F312 483.25(a)(3) ACTIVITIES OF DAILY LIVING 1. Resident's #5 and 14 remain in the center and have been seen by the podiatrist for nail care. Current resident's have been assessed and if necessary have been seen by the podiatrist. 2. In-servicing shall be held on or before March 16, 2009, for nursing staff on nail care. 3. Monthly and periodic rounds shall be completed to determine compliance with nail care. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. F315 483.25(d) URINARY INCONTINENCE 1. Resident #23 no longer resides at the center. Current residents on antibiotics have been reviewed to determine proper transcription and administration. Current residents with urine cultures ordered or completed prior to admission are monitored to determine the results are received in a timely manor. Current resident's goals for care have been reviewed and plan of care revised. 2. In-servicing shall be held on or before March 16, 2009 for licensed nursing staff on Lab study results, transcription of physician orders, and care planning. 3. Audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. F323 483.25(H) ACCIDENTS AND SUPERVISION 1. Resident #5 remains in the center. Potential hazardous liquids have been removed from the resident's room. Rounds have been completed throughout the facility to determine that resident areas are free from potential accident hazards. 2. In-servicing shall be completed for facility staff on accident hazards on or before March 16, 2009. 3. Monthly and periodic rounds shall be completed to determine compliance. This shall be the responsibility of the DON/designee. Continued →

4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F329 483.25(l) UNNECESSARY DRUGS

1. Resident's #1, 8, and 15 remain in the center. Resident's # 1 and #8 have appropriate documentation for PRN administration of their medications. Residents #1 and 8 have been reviewed by the ICP team and their plans of care have been updated as necessary to reflect their current level of care. Resident #15 has been assessed for side effects of the Abilify. Resident #13 no longer resides in the center. Current residents have been reviewed for documentation related to the need for PRN medications and monitoring of side effects of antipsychotic medications.
2. In-servicing shall be completed on or before March 16, 2009 for licensed nurses on documentation related to administration of PRN medications and AIMS testing for antipsychotic medications.
3. Monthly and periodic audits shall be completed to determine compliance. This shall be the responsibility of the DON/designee.
4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F425 483.60(a),(b) PHARMACY SERVICES

1. Resident #21 no longer resides in the center. Current and new resident's medication orders are being received from the pharmacy in a timely manner. This scenario largely eliminated by the installation of an Omnicell for 24-hr. on-site drug availability.
2. In-servicing shall be completed on or before March 16, 2009 on obtaining meds from pharmacy.
3. Monthly and periodic audits shall be completed to determine compliance; this shall be the responsibility of the DON/designee.
4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 1/9/09, F312, F315, F323 and F329, F425.	
3201.9.2.3	**All orders for medications, treatments, diets, diagnostic services, etc. shall be in writing and signed by the attending physician.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 1/9/09, F514.	3201.9.2.3 All orders meds, etc… Shall be in writing and signed by physician; cross refer F514 F514 483.75(l)(1) CLINICAL RECORDS 1. The records of resident's (#2, #3, #5, #6, #7, #8, #10, #15 and #19) have been reviewed and corrective action; where possible, is taking place and will be completed no later than March 16, 2009. 2. Discussions and training regarding this standard of care have been completed with the appropriate physician's and the Medical Director. 3. Monthly and periodic audits shall be completed to determine compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.
3201.9.2.4	**All orders shall be renewed and signed by the physician at least every thirty (30) days.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 1/9/09, F514.	3201.9.2.4 Orders shall be renewed and signed by physician every (30) days; cross refer F514 F514 483.75(l)(1) CLINICAL RECORDS 1. The records of resident's (#2, #3, #5, #6, #7, #8, #10, #15 and #19) have been reviewed and corrective action; where possible, will be completed no later than March 16, 2009. 2. Discussions and training regarding this standard of care have been completed with the appropriate physician's and the Medical Director. 3. Monthly and periodic audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.
3201.9.2.5	**A progress note shall be written and signed by the physician on each visit.**	3201.9.2.5 All progress notes shall be written and signed by physician each visit; cross refer F387 F387 483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS 1. The records of resident's (#2, #3, #5, #6, #7, #8, #10, #15 and #19) have been reviewed and corrective action; where possible, to be completed no later than March 16, 2009. Continued →

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3201.9.10 1.2	**This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 1/9/09, F387. **History and physical examination: Prepared by a physician within seven (7) days of the patient's admission to the home. If the patient has been admitted to the home immediately after discharge from a hospital, the patient's summary and history which was prepared at the hospital and the patient's physical examination which was performed at the hospital, if performed within seven (7) days prior to admission to the home, may be substituted in lieu of the above records. Additionally, a record of an annual medical evaluation performed by a physician must be contained in each patient's file.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that the facility failed to ensure that one (#7) out of 23 residents had a current history and physical by their medical doctor. Findings include: Resident #7's last history and physical was dated 10/11/07. An interview with administrative staff	F387 Continued → 2. Discussions and training regarding this standard of care have already taken place with the appropriate physician's and the Medical Director. Weekly audits and "to do" lists are in place and being monitored. 3. Weekly and periodic audits are being conducted to monitor compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. 3201.9.101.2 H&P Examinations within (7) days… and Annually 1. The records of resident's (#2, #3, #5, #6, #7, #8, #10, #15 and #19) have been reviewed and corrective action; where possible, to be completed no later than March 16, 2009. 2. Discussions and training regarding this standard of care have already taken place with the appropriate physician's and the Medical Director. 3. Weekly and periodic audits are being done to monitor compliance; this shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

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	confirmed that there was not a current history and physical on file.	BLANK

Provider's Signature Alex "Lou" / NHA Title Administrator Date 3/11/09

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